WIC Medical Documentation Form

North Dakota Department of Health - Division of Nutrition and Physical Activity- WIC Program

To authorize a special WIC-approved formula, medical food, or milk substitute, complete this form, then fax to _____ or have the participant return it to their local WIC office.

Participant's Name: _____ **Date of Birth:** _____

Parent/Guardian's Name: _____

Section 1: Complete if prescribing a special formula or medical food.

WIC Special Formula/Medical Food Requested: _____

Medical Diagnosis: _____
(Formula intolerance, spitting up, or colic are not acceptable medical diagnoses.)

Time Needed: ☐ 1 mo ☐ 2 mo ☐ 3 mo ☐ 6 mo **Prescribed Amount:** ☐ Full Amount Allowed OR _____ oz/day

WIC Foods: (Check ONE box only.)

☐ Issue full amount of age-appropriate WIC foods;

OR

☐ Issue **no WIC foods**; provide formula only;

OR

☐ Issue a food package **without** the WIC foods checked below.

Infants (6 through 11 months) ☐ Infant Cereal ☐ Baby Food Fruits/Vegetables ☐Baby Food Meats

Children (1 through 4 years old) and Women ☐ Cheese ☐ Cereal ☐ Juice ☐ Eggs ☐ Beans/Peas

☐ Whole Wheat Bread/Brown Rice/Tortillas ☐ Peanut Butter ☐ Fruits/Vegetables ☐ Tuna/Salmon ☐ Milk

Whole Milk: ☐ Issue whole milk for a child over 2 or women. Only participants receiving formula with a qualifying medical condition can get whole milk. (WIC regulations specify 2%, 1%, or skim milk for women and children 2 years of age and older.)

Instructions/Comments: _____

Section 2: Complete if participant needs a milk substitute.

Milk Substitute requested: ☐ Soy based beverage for children ☐ > 1 pound cheese for women or children

Medical Diagnosis: ☐ Milk Allergy ☐ Severe Lactose Maldigestion ☐ Vegan Diet ☐ Inadequate Weight Gain (pregnant women)
☐ Underweight ($\leq 5^{th}$ percentile weight/length or BMI for children or underweight BMI for women)
☐ Other: _____ (Personal preference is not an allowed reason.)

Time Needed: ☐ 3 mo ☐ 6 mo ☐ 12 mo ☐ Indefinite **Comments:** _____

Section 3: Complete for all.

Signature of Health Care Provider: _____ **Date:** _____

Health Care Provider's Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA

Clinic/Address: _____

Phone Number: _____ **Fax Number:** _____

For more information or help in completing this form: Contact _____at _____.